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UNICEF joint health and nutrition strategy for 2006-2015

Summary

The joint health and nutrition strategy defines the UNICEF contribution to national efforts to accelerate health and nutrition action and achieve the Millennium Development Goals by 2015. In the context of United Nations reform, the strategy will complement and reinforce the strategic directions of other major organizations, especially in areas where UNICEF has a primary mission or comparative advantage. It represents an evolutionary development from the 1992 nutrition and 1995 health strategies, based on lessons learned and a changing programmatic context, and has been developed through a process of intensive consultation with a wide range of key partners and UNICEF staff.

Drawing on the synergy between health and nutrition to guide its work, UNICEF, in collaboration with partners, will focus on supporting three interrelated, strategic results in the areas of maternal, newborn and child health and nutrition: (a) evidence-based analysis for policy and action; (b) development of enabling institutional frameworks; and (c) large-scale acceleration of effective coverage of interventions.

The strategy is based on five guiding principles and three implementation approaches to achieve and sustain high levels of effective and equitable coverage of maternal, newborn and child health and nutrition interventions. Implications for UNICEF are identified. The strategy will inform the development of the UNICEF medium-term strategic plans during the reference period.

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I. Context, lessons learned and rationale

A. Context

1. A child's right to survival and development is the first fundamental principle underlying the Convention on the Rights of the Child. At the current rate of progress, neither the Millennium Development Goal of reducing under-five mortality by two thirds from 1990 levels (Goal 4) nor the other health- and nutrition-related Goals will be achieved unless effective health and nutrition interventions are implemented at high rates of coverage in geographic areas within and across countries with high levels of mortality and undernutrition[1] among mothers, newborns and children under five years of age.

2. Every year, an estimated 10.6[2] million children are denied their right to survival, dying before they reach the age of five years. In addition, half a million women die in pregnancy each year, most during delivery or in the first few days thereafter. The enormous death toll is only part of the burden. Hundreds of millions more women and children suffer undernutrition, illness and long-term disability. Although the last two decades have seen some progress in reducing post-neonatal deaths, much less attention has been paid to the almost 40 per cent of deaths that occur in the first week of life. The Goals for child survival will not be met without substantial reductions in neonatal mortality and child undernutrition.

3. Most under-five deaths are clustered in two regions: sub-Saharan Africa (44 per cent) and South Asia (32 per cent[2]). Seven of the ten countries with the highest under-five mortality rates (U5MR)[2] have been affected by complex emergencies, which increase risks to the health and nutrition of mothers and children. Even within countries where death rates are declining, there are areas and populations where mortality remains high. Disproportionately high levels of under-five undernutrition are evident in South Asia and parts of sub-Saharan Africa, with high rates of wasting often the consequence of complex emergencies, recurrent droughts and other natural disasters.

4. Most maternal, newborn and child deaths occur in poor communities. Nearly all deaths among children under five years of age (99 per cent) occur in low-income countries or the poor areas of middle-income countries. Poor health and nutrition in the early years of life perpetuate the cycle of poverty and intergenerational under-achievement for poor families and societies.

5. The primary causes of child deaths worldwide are pneumonia, followed by diarrhoea, low birth weight and prematurity, asphyxia at birth and, in some regions, malaria and HIV/AIDS. The direct causes of deaths during complex emergencies are essentially the same as in normal situations in developing countries.

6. Although 3 per cent of global U5MR is attributable to HIV, the rate increases to about 60 per cent in Southern Africa, where HIV prevalence among pregnant women exceeds 20 per cent. The increasing feminization of the HIV epidemic in Asia, if unaverted, will culminate in many more children becoming infected through mother-to-child transmission. In 2004, according to the Joint United Nations Programme on HIV/AIDS (UNAIDS), about 2.2 million children under the age of

[1] Deficient nutritional status of children expressed as stunting and wasting.

[2] Source: *The State of the World's Children 2005*.

15 years were living with HIV, 640,000 were newly infected and 510,000 died. Currently, close to 90 per cent of paediatric infections are in sub-Saharan Africa, the hub for over 60 per cent of the global HIV disease burden. In developing countries, fewer that 10 per cent of HIV-infected pregnant women have access to antiretroviral preventive treatment. Although there is much progress in implementing programmes for the prevention of mother-to-child transmission of HIV (PMTCT) in Latin America and Eastern Europe, only 1-2 per cent of HIV-infected women in West and Central Africa and 11 per cent in Eastern and Southern Africa benefit from these interventions.

7. The nutritional and health status of young children is the outcome of three underlying factors: (a) access to and utilization of adequate foods (considering quantity, quality, safety and socio-cultural acceptability); (b) the effectiveness of health services and healthiness of the environment (considering resources, opportunities and the roles and responsibilities of duty bearers); and (c) the quality and level of maternal and child care. As a result, addressing undernutrition is not simply a matter of food. Caring behaviours, including exclusive breastfeeding for the first six months of life, continued breastfeeding with appropriate and timely complementary feeding, nutrient-dense foods and supplementation where necessary, are all essential interventions to reduce child deaths and promote healthy development.

8. Inappropriate feeding practices lead to increased exposure to microbiological contamination and leave children with weakened immune systems, resulting in excess illness and reduced growth. Even when a child survives her early years, undernutrition and repeated infections can lead to life-long developmental delays.

9. Maternal, newborn and under-five child deaths and undernutrition share a number of similar and interrelated underlying and structural causes, such as food insecurity; female illiteracy; early pregnancy; poor birth outcomes including low birth weights; inadequate feeding practices; lack of hygiene and access to safe water or adequate sanitation; discrimination and exclusion of mothers and children from access to health and nutrition services due to poverty, geographic or political marginalization; and poorly resourced, unresponsive and culturally inappropriate health and nutrition services. These intertwining causes result in millions of unnecessary deaths, suffering and loss of human potential, and need to be tackled at different levels, within the household and between the family, the community, service providers and the nation. Achieving the health- and nutrition-related Millennium Development Goals requires political, institutional and societal solutions as well as technical ones.

B. Lessons learned

10. A key objective of efforts to accelerate and maintain improvements in the nutritional and health status of mothers and children is to ensure that households function as viable social and economic units capable of providing the food, health and care needed. Community nutrition programmes that encourage the full participation and cooperation of the entire community, maximize the use of local resources, benefit from new technologies for productivity gains, involve multiple sectors and engage strong political commitment are vital tools for improving maternal and child health and nutrition.

11. Solutions do exist to prevent maternal and child deaths and reduce undernutrition, but often do not reach those most in need. The direct causes of maternal, neonatal and young child deaths are known and are largely preventable and treatable using proven and cost-effective interventions and practices (see annex 1). Recent series in *The Lancet*[3] have estimated that around two thirds of both neonatal and young child deaths, equivalent to over 6 million deaths every year, are preventable with existing low-cost, low-technology interventions. For example, an estimated 1.4 million and 1.1 million deaths respectively are preventable with currently available vaccines and future vaccines.[4] Further, recent evidence indicates that children with HIV perform well on antiretroviral treatment, with survival rates of up to 73 to 98 per cent, depending on the degree of immune deterioration.[5] Co-trimoxazole preventive treatment in sick HIV-infected children with immune deterioration has been shown to reduce mortality by as much as 43 per cent.[6]

12. To save these lives, the necessary interventions involve a continuum of care throughout pregnancy, childbirth and after delivery, leading to care for children in the crucial early years of life.

13. Countries and regions failing to make progress towards the health- and nutrition-related Millennium Development Goals are overwhelmingly those with high levels of young child mortality, food insecurity and fragile institutional environments. Institutions are weakest in countries affected by complex emergencies. This pattern reflects the greater challenges of reaching the goals in poorer countries, and in poor communities in rich countries, which have very high initial levels of maternal, newborn and young child mortality and undernutrition.

14. In many of these countries, coverage of proven health and nutrition interventions and practices remains low due to profound disconnects between knowledge, policies and action, manifesting themselves as system-wide supply and demand obstacles. To scale up these interventions and practices and to sustain high coverage, it is important that the underlying conditions for performance of the health and nutrition systems, including policies, legislation, resource allocation and capacity development, be both built up and transformed.

15. All aspects of service delivery need to be strengthened, including qualified and motivated workers accessible to all communities, adequate physical infrastructure and sustainable and "pro poor" financing mechanisms. Delivering these interventions requires strengthening the underpinnings of service delivery at all levels: clinical services at both primary and referral hospitals levels; and outreach and community-based services. For sustainable improvements in health and nutrition, linkages are needed between social sectors (such as health and education) with productive sectors (such as agriculture and markets). It is also essential to

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[3] The first series of five papers focused on child survival and began with Black R., Morris S., and Bryce J., "Where and why are 10 million children dying every year?", *Lancet* 2003; 361:2226-34. The second series focused on neonatal survivial and began with Lawn JE, Cousens S., Zupan J., "4 million neonatal deaths: When? Where? Why?", *Lancet* 2005; 365:891-900.

[4] Ref.

[5] Fassinou P., Elenga N., Rouet F., et al. Highly active antiretroviral therapies among HIV-1-infected children in Abidjan, Côte d'Ivoire, *AIDS* 2004. 18(14): 1905-1913.

[6] Chintu C., Bhat GJ, Walker AS, et. al., "Co-trimoxazole as prophylaxis against opportunistic infections in HIV-infected Zambian children (CHAP): a double-blind randomised placebo-controlled trial", *Lancet* 2004; 365: 1865-71.

change existing behaviours and practices, especially in countries with low-quality services, through active community involvement and participation.

16. Experience shows that some of these interventions can go to scale more easily than others under existing institutional and system limitations, because the obstacles to their scaling up can be addressed relatively quickly through outreach services and strengthening of community-level action. Other interventions, including individually-oriented care in response to illness, are more constrained by systems and accountability obstacles, and cannot be scheduled in advance. Obstacles to the comprehensive implementation of the "continuum of care" concept must be addressed, but this will take time and financial resources, especially in countries with high mortality and HIV prevalence rates, where health, food and nutrition systems are usually weak.

17. Enabling institutions, laws, policies, budgets and participatory governance are important for the large-scale expansion of high-impact interventions. They underpin efforts to create the conditions in which all citizens can participate fully in the development process and help shape service delivery and public policy to extend quality services to the poorest and most excluded groups.

18. Meaningful participation and capacity-building can help equip families and women with the knowledge required to make informed decisions about adequate day-to-day caring behaviour, the provision of life-saving interventions and adequate care-seeking behaviours. Communication strategies can empower families and women with knowledge about available services and the standard of service quality they should expect from both the State and private sector.

19. Global health and nutrition partnerships have been instrumental in advocating for and raising the profile of health and nutrition for mothers and children both nationally and internationally. However, the recent proliferation of such partnerships, often in parallel with existing donor activities at the country level, may create or exacerbate poor coordination and duplication and reduce national ownership. The five best practice principles for aid effectiveness (ownership, alignment, harmonization, managing for results, mutual accountability) adopted in the Paris Declaration on Aid Effectiveness provide a useful framework for exploiting the opportunities provided by these partnerships to their full potential.

C. Rationale

20. It has been some 10 and 13 years, respectively, since the Executive Board approved the current individual UNICEF strategies on health and nutrition. The basic principles of these strategies remain relevant and valid, and have in fact been mainstreamed since their inception.

21. The proposed joint health and nutrition strategy introduces a number of significant additions to past strategies in response to the new international

development agenda; the reform of the United Nations system; current trends[7] in child, newborn and maternal health and nutrition; organizational lessons learned; important scientific analyses; and changing global conditions such as increasing decentralization, widening inequities, concern over gender equality issues, environmental deterioration, multiplication of complex emergencies and the continuing HIV/AIDS pandemic.

22. Of the eight Millennium Development Goals, four (Goals 1, 4, 5, and 6) are directly related to child and maternal health and nutrition, and the remaining four (Goals 2, 3, 7, and 8) are strongly linked to these areas. The joint strategy is designed to focus on the achievement of the health and nutrition Goals, and guide UNICEF until at least 2015. The strategy will be reviewed and updated periodically as new evidence emerges, and will guide the implementation and development of the current and future medium-term strategic plans (MTSP) in the next decade.

23. A joint health and nutrition strategy will increase the impact of UNCEF activities. Improved convergence of approaches, programme strategies and interventions will lead to greater effectiveness and enhanced outcomes. Solutions to accelerate health and nutrition action in support of child survival are interactive and synergistic not only with each other, but also in relation to child growth and development and maternal health. The proposed strategy also complements other major strategies, including the new UNICEF water, sanitation and hygiene strategies for 2006-2015 (E/ICEF/2006/6) to reduce the impact of diarrhoeal diseases, parasitic infections and acute respiratory infections on child survival and undernutrition. Similar complementarities exist in the areas of education, especially school health programmes and early childhood development, and UNICEF activities to support countries in post-crisis transition.

II. Strategic intent and results

24. The strategy defines the UNICEF contribution to national efforts to accelerate health and nutrition action to achieve the Millennium Development Goals by 2015. In the context of United Nations reform, the strategy aims to complement and reinforce the strategic directions of other major organizations, especially in areas where UNICEF has a primary mission or comparative advantage. Drawing on the synergy between health and nutrition and in collaboration with other partners, UNICEF will focus on supporting interrelated, strategic results in the areas of maternal, newborn and child health and nutrition:

(a) **Strategic result 1 — evidence-based situation analysis for policy and action**. Situation analyses supported by disaggregated and recent data on maternal and child health and nutrition are available and used to guide evidence-based policy and action globally and in all countries;

[7] Strategic Directions for Improving the Health and Development of Children and Adolescents (WHO, 2003); Global Strategy on Infant and Young Child Feeding (WHO/UNICEF, 2002); Global Immunization Vision and Strategy (UNICEF/WHO, 2005); Children and Youth: A Framework for Action (World Bank, 2005); World Development report (2004), World Health Report (2005), Report of the Millennium Project (2005); The prevention of mother-to-child transmission of HIV: WHO strategic recommendations (2002).

(b) **Strategic result 2 — the development of enabling institutional frameworks**.[8] Institutional frameworks resulting from combined health and nutrition action and intersectoral exchange are used to prioritize resources and strategies and accelerate progress towards all Goals, with particular attention to Goals 1, 4, 5, and 6, in all programme countries;

(c) **Strategic result 3 — large-scale acceleration of effective coverage of interventions**. Effective coverage of interventions supporting Goals 4 and 5 is accelerated in countries and regions with high maternal and child mortality rates, with a particular focus on emergency situations.

Table 1
Strategic results of the joint health and nutrition strategy

Strategic result	*Programmatic focus*	*Geographic focus*	*Relevance to MDGs*
1	Situation analyses	Globally and in all programme countries	Includes but goes beyond Goals 1, 4, 5 & 6
2	Institutional frameworks	All programme countries	Accelerates progress towards Goals 1, 4, 5 and 6; supports progress towards other Goals, through policy inputs from health and nutrition sectors, cross-sectoral exchange and adaptation of proven strategies and tools
3	Effective coverage	Programme countries and geographic regions within countries with high maternal, neonatal and/or under-five mortality rates or numbers of deaths, with a particular focus on countries facing emergencies	Specific focus on Goals 4 & 5

III. Guiding principles

A. Working in partnership

25. In line with the accepted best practice principles for aid effectiveness established in the Paris Declaration, UNICEF is committed to support those global health and nutrition partnerships within which partner countries exercise effective leadership over their development policies and strategies and have responsibility for coordinating development actions. Donors need to base their overall support on partner countries' national development strategies, institutions and procedures and ensure that their actions are harmonized, transparent and collectively effective. At the country level, UNICEF will advocate for maternal, newborn and child health and nutrition planning, coordination and monitoring arrangements, operating within existing sector-wide coordination mechanisms under government leadership.

[8] Supported by evidence and adapted to the context of the country.

UNICEF will direct high programmatic intensity to areas of health and nutrition that are central to its mission ("first call for children") and MTSP. UNICEF will complement and build on the work of other United Nations agencies and technical assistance partners through joint planning and programming.

B. Selecting evidence-based interventions and operational strategies using a life-cycle approach

26. UNICEF will support evidence-based, high-impact health and nutrition interventions and practices, which, if jointly scaled up and widely applied, will have a dual and synergistic impact not only on survival but also on growth and development. The strategy's life-cycle approach seeks to ensure a continuum of care from pregnancy through childhood. UNICEF recognizes that optimal child survival, growth and development are more likely to be achieved and sustained if preventive measures are already available to future mothers (adolescent girls and women) before their children are born, as part of an integrated approach to reproductive, maternal, newborn and child health.

C. Remaining results- and systems-oriented

27. UNICEF recognizes that the health and nutrition of mothers and children are embedded in a complex web of social, cultural, economic and epidemiological circumstances. The end result of improved health and nutrition must be kept clearly in view while working with Governments and partners to identify and address obstacles through high-quality processes.

D. Applying a rights-based approach to programming

28. The principle of the right of the child to survival and development is the foundation for UNICEF programmes of cooperation and support to the United Nations Development Assistance Framework (UNDAF) and the Millennium Agenda. Together, the principles of non-discrimination, the best interests of the child, participation and taking into account the views of the child guide how these goals and actions are pursued. As a result, this strategy aims to: (a) reach unreached, marginalized, discriminated against and excluded children, women and families whose rights have been denied and who have little or no access to quality, equitable and affordable health and nutrition services, especially the poor and those affected by emergencies; (b) build capacities and empower rights-holders, specifically poor children, adolescents, women, families and communities, to make optimal choices, participate in decision-making and engage in practices and adapt behaviours that have a direct and positive impact on their health, nutrition and well-being; and (c) increase and monitor the performance of duty bearers and build their capacities as needed.

29. Although targeted efforts are necessary to correct the most immediate causes of deprivation in the short term, longer-term efforts are also needed to correct more basic contributors to socio-economic inequities and gender inequalities that have negative effects on health and nutrition outcomes. UNICEF will support national

and subnational institutional frameworks that seek to address inequities in the short and long terms.

E. Working at micro, meso, macro and global levels

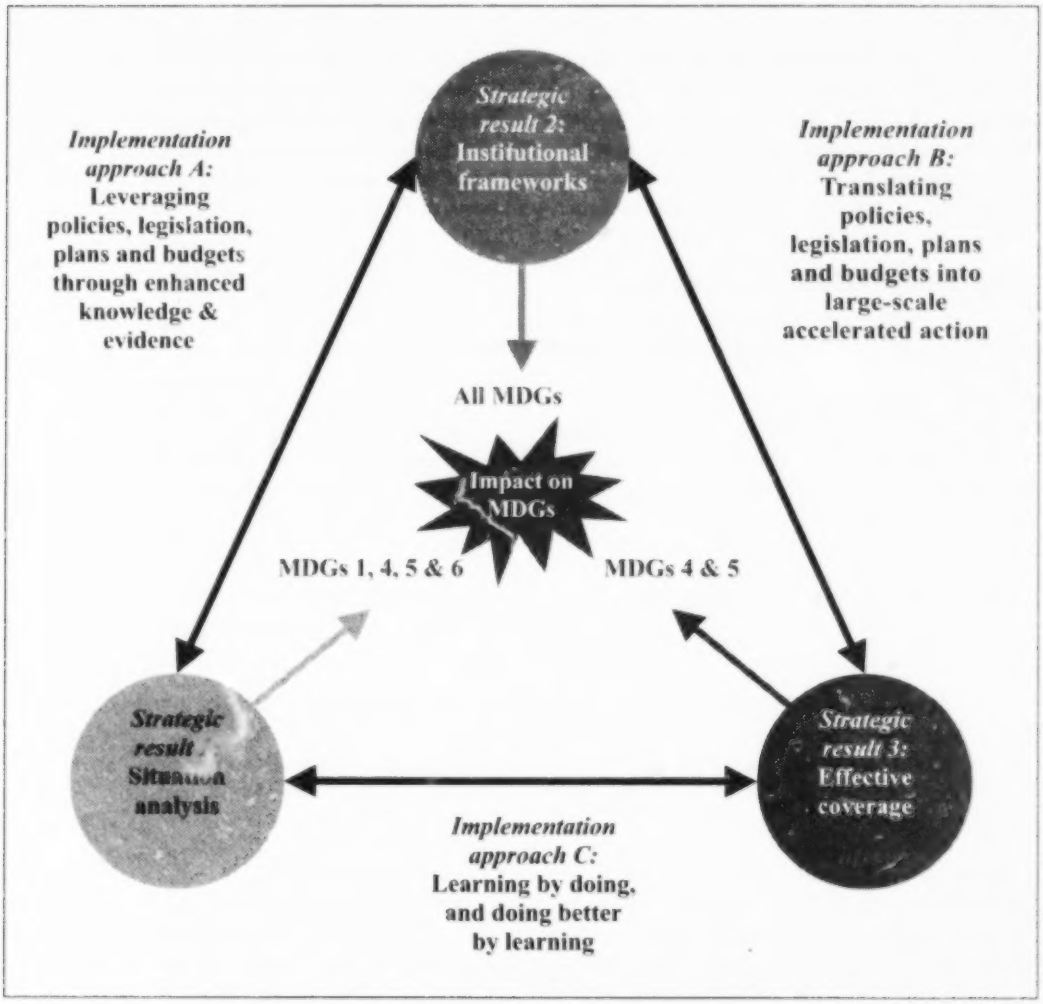
30. In an increasingly globalized world, the strategy emphasizes the need to develop appropriate linkages between concerted international action and national development frameworks. At the national (macro) level, the strategy supports policies, processes and interventions. At the community/subnational (meso) level, the strategy is guided by the need to provide effective health and nutrition services and commodities. At the household/family (micro) level, complementary actions are supported to stimulate appropriate behaviours, practices, and choices.

IV. Implementation approaches

A. Conceptual framework for implementation

31. he three strategic results are complementary and therefore require implementation approaches aimed at optimizing their dynamic interaction. The figure below draws on the "triple-A" concept (assessment-analysis-action) to clarify the strategy's three main implementation approaches, which are described below.

Figure
Conceptual framework for implementation of the UNICEF joint health and nutrition strategy


Strategic result 2: Institutional frameworks
Implementation approach A: Leveraging policies, legislation, plans and budgets through enhanced knowledge & evidence
Implementation approach B: Translating policies, legislation, plans and budgets into large-scale accelerated action
All MDGs
Impact on MDGs
MDGs 1, 4, 5 & 6
MDGs 4 & 5
Strategic result 1: Situation analysis
Strategic result 3: Effective coverage
Implementation approach C: Learning by doing, and doing better by learning

B. Implementation approach A: Leveraging policies, legislation, plans and budgets through enhanced knowledge and evidence

32. This implementation approach links strategic result 1 (situation analysis) with strategic result 2 (institutional frameworks). A primary linking mechanism is the generation of data and analyses on a broad range of maternal and child health and nutrition issues. The stepwise process includes five overlapping and iterative steps:

(a) **Identification of priority information needs**. The existing UNICEF analytical framework (see annex) has proven useful in the analysis of health and nutrition outcomes and their determinants among mothers and children. The framework will therefore continue to be adapted to specific country contexts and used with stakeholders, as a basis for developing a plan for generating and disseminating needed information. Most country programmes will need access to recent, high-quality and disaggregated data on:

(i) Maternal and child epidemiology, including mortality, morbidity and undernutrition and their causes;

(ii) Effective coverage of evidence-based, high-impact health and nutrition interventions, as well as the reasons for gaps in effective coverage (e.g., family and community practices, availability of essential resources, geographical and financial access, utilization, compliance and quality of services). The value of analysing the coverage of interventions by where and how the service was delivered is increasingly recognized, given the potentially limited reach of facility-based services and even outreach;

(iii) Data on provision and utilization of services, especially among mothers and children who are likely to be excluded because of geographical, social, political, economic, ethnic and gender marginalization. The recommendations of the Committee on the Rights of the Child and the Committee on the Elimination of Discrimination against Women on State party reports will be useful in this regard;

(iv) Information and evidence on any known (or anticipated) positive or negative effects of existing (or proposed) health and nutrition sectoral policies, strategies and inputs on non-health/-nutrition outcomes and Goals will be useful given the well-known "outward links" from health and nutrition sectors to wider development processes;

(b) **Data collection and analysis**. Methods of data collection include such quantitative methods as censuses, household surveys, vital registration and health status and service records systems, as well as qualitative methods (focus groups and participatory inquiries). UNICEF will continue to support multiple indicator cluster surveys (MICS), Demographic and Health Surveys (DHS) and Standardized Monitoring and Assessment for Relief and Transition (SMART), with an emphasis on data quality. In line with its global monitoring responsibilities and within collaborative frameworks such as the Health Metrics Network or the Child Health Epidemiology Reference Group, UNICEF will support the strengthening of national health and nutrition information and surveillance systems, work with partners to identify significant knowledge and evidence gaps, and support data collection efforts and action-oriented research designed to help fill those gaps. UNICEF will also support further development of the evidence base by encouraging rigourous assessment of relevant experiences of reducing financial barriers to access to health and nutrition services, and by stimulating operations research and demonstration pilots as described below under implementation approach C;

(c) **Identification of policy options**. This step brings the results of the data collection and analysis (step 2) together with state-of-the-art evidence on the effectiveness, cost and impact of alternative interventions and policy choices. The result is a country-specific list of policy options for achieving Goals 4 and 5 for

consideration by the Government and its partners in maternal and child health and nutrition. A key criterion in the assessment of policy options is the probability that a given choice will contribute to increasing effective delivery of priority interventions to high, sustained and equitable levels of coverage. Examples of policy choices likely to support progress towards health and nutrition Goals include the adoption of the International Code on the Marketing of Breastmilk Substitutes, support for trained community-level workers to treat pneumonia using first-line antibiotics, or exempting insecticide-treated materials for the prevention of malaria from import taxes;

(d) **Developing national and subnational institutional frameworks that support the Millennium Development Goals**. UNICEF will support and participate in various types of communication with policymakers and stakeholders to decide on the most cost-effective policies and strategies that are feasible in the local context. This will involve presenting the policy options and their implications user-friendly ways, using such tools as DevInfo. UNICEF intends to increase its support to this step by working with such partners as the World Bank and the World Health Organization (WHO) to develop, test, apply and evaluate a spectrum of tools intended to improve priority-setting, planning and results-based budgeting at national and subnational levels. Examples include the Marginal Budgeting for Bottlenecks tool or the tools under development by the WHO "Choice" project. This iterative and interactive process will lead to national policies, plans and budgets that are specifically targeted at achieving progress towards the Goals, especially those directly related to maternal, newborn and child health and nutrition;

(e) **Leveraging resources for Goals 4 and 5**. Finally, UNICEF will assist countries in identifying and filling gaps in financial support needed to implement their health and nutrition policies and plans. Mechanisms will include analyses of the donor environment, development of sustainability plans based on projections and results-based budgeting frameworks that link investments with expected outcomes and impact, and vigourous advocacy. Difficult trade-offs are and will continue to be needed in most countries, and with decentralization of budgets these choices increasingly are made at the subnational level. Working closely with the development banks, UNICEF will support and assist countries to make the best use of available resources for mothers and children from all sources — governmental, international, private sector and households.

C. Implementation approach B: Translating policies, legislations, plans and budgets into large-scale accelerated action

33. Implementation approach B links strategic result 2 (institutional frameworks) to strategic result 3 (effective coverage). UNICEF will support Governments in achieving equitable and sustained increases in coverage for an essential set of preventive and case-management interventions, which together can reduce mortality. Special attention will be given to those interventions that address both health and nutrition outcomes. In addition, UNICEF will continue to apply its Core Commitments for Children in Emergencies.

34. UNICEF will contribute to processes, normally involving a range of national and international partners with normative responsibilities such as the Food and Agriculture Organization of the United Nations (FAO) and WHO, to review

available epidemiological and other evidence as a basis for selecting a limited number of cost-effective interventions that can achieve major reductions in maternal, newborn and child mortality. Annex 1 serves as a starting point for country-relevant, cause-specific, priority interventions that will expand as new evidence becomes available. This evidence based selection of interventions and the setting of coverage targets for each of them in order to achieve Goals 4 and 5 will be guided by the processes in implementation approach A.

35. Interventions will be categorized as: (a) universal (e.g., immunization, breastfeeding and complementary feeding, emergency obstetric care; (b) situational (e.g., malaria prevention and control, programmes for HIV-positive mothers and cotrimoxazole prophylaxis for their children, antenatal detection and treatment of syphilis); and (c) additional (e.g., in areas with lower U5MR where systems and services are usually stronger but neonatal mortality remains a problem. additional interventions such as screening and management of asymptomatic bacteria, antibiotics for premature rupture of membranes, corticosteroids for pre-term labour and periconceptual folate supplementation may be indicated). However, the number of interventions will be minimized to balance highest effectiveness with highest feasibility, because actions required to roll out each intervention are required simultaneously at global, national, subnational, community and household levels.

36. Countries experiencing the greatest challenges are often characterized by weak and inequitable health and nutrition systems and services and poor governance, as in complex emergencies. Such an approach therefore implies addressing systemic obstacles in order of priority, implemented according to country-specific situations and a good understanding of culturally acceptable practices. Extensive UNICEF experience in countries, reinforced by the experience of others and evidence from effectiveness evaluations, suggests the following:

(a) **The value of integration**. Although many of these interventions represent separate programmes, it is vital that they be taken to scale in an integrated and system-building manner to ensure sustainability;

(b) **The importance of subnational and community-based planning and budgeting**. Working with WHO, the World Bank and other United Nations and bilateral agencies, UNICEF will support the strengthening of subnational plans focused on identifying and addressing priority supply- and demand-related obstacles and opportunities to support: (i) capacity-building and empowerment of poor communities to improve family-/community-level care; (ii) reaching the unreached to ensure universal coverage with outreach services; and (iii) ensuring the availability of affordable, quality clinical care in poor districts;

(c) **Starting with what is feasible given the strength of the health and nutrition systems in a country**. In countries with relatively weak health and nutrition systems and services, the initial focus will be on interventions that are less reliant on the health system and can be delivered at community level or through outreach. All children should have access to basic preventive and health-promoting interventions and to case management for locally prevalent causes of death (e.g., interventions for malaria and HIV/AIDS or vitamin A may not be needed in some areas);

(d) **Aiming for universal coverage to save lives and reduce inequities**. Working with partners, UNICEF will support Governments to achieve universal

coverage of interventions like immunization, vitamin A, insecticide-treated materials for the prevention of malaria, deworming and intermittent presumptive therapy for pregnant women, with a particular focus on reaching poor, hard-to-reach and marginalized communities and families. This will be done through the regular supply of outreach and mobile teams, performance incentives, defaulter tracking or periodic campaigns such as national health days with an integrated package, especially in fragile States and emergencies. Particular attention will be paid to ensuring that scaling up these interventions is part of outcome-oriented sector plans;

(e) **Empowering and building the capacities of poor communities, women and families for combined delivery of multiple interventions at community level that support the "continuum of care concept"**. This will include recognition of danger signs and improved care- seeking behaviours, as well as improved behaviours and practices for a number of key maternal, newborn and child survival interventions, including PMTCT-plus, delivery of cotrimoxazole to HIV-infected children and psychosocial support for orphans and other vulnerable children (see annex 1). Experience has shown that deeply rooted caring behaviours can be changed using approaches that aim to raise community awareness and their involvement in health and nutrition programmes. For example, trained community volunteers can visit houses in their neighbourhoods to improve infant feeding and set up community mapping and monitoring systems. UNICEF acknowledges the importance of monitoring growth of children at the individual and community levels and will review this intervention for improved action. Extensive experience gained over decades with integrated community-based approaches must now be scaled up and implemented more widely;

(f) **Scaling up quality maternal and child health care in health facilities**. Through joint programming, UNICEF will support national and subnational frameworks that provide the necessary policy and financial conditions to overcome system-wide obstacles to improved facility-based maternal and child health and nutrition services. UNICEF support to facility-based emergency obstetric care, the Integrated Management of Childhood Illness (IMCI), PMTCT-plus and the care, treatment and support of children infected and affected by HIV will prioritize poor districts. Key operational strategies may include delegating tasks to lower-level health staff trained and supported to ensure quality; contracting non-governmental organizations (NGOs), especially in fragile States and emergencies; or reviewing financing mechanisms (e.g., exempt, insure or subsidize the poor or abolish fees for emergency obstetric care, PMTCT-plus and IMCI);

(g) In countries where UNICEF has a leading or secondary role in supporting Governments to achieve Goal 5, there will be a positive effect on newborn and child health and nutrition and on the entire life cycle more generally, through advocating delaying the age of marriage and first birth, improving adolescent nutrition and life skills and fostering gender equality. In collaboration with and complementary to the work of the United Nations Population Fund, the United Nations Office on Drugs and Crime, WHO and other partners, UNICEF will support national and subnational programmes to provide age-relevant, gender-sensitive sexual and reproductive health information, skills and services to reduce child and adolescent risk and vulnerability to HIV.

37. When these interventions are grouped according to age-specific contacts with health and nutrition services, the number of interventions that can be delivered

during each contact can be optimized. For example, immunization contacts can be linked with other interventions such as the distribution of insecticide-treated materials for the prevention of malaria, vitamin-A supplements and information-sharing on infant feeding. Special attention to equity is needed when combining services for delivery, as the same more privileged mothers and children may receive more and more interventions while those who are excluded continue to receive none.

D. Implementation approach C: Learning by doing and doing better by learning

38. Implementation approach C links the third strategic result (effective coverage) with the first (situation analysis). The aim is to use the lessons learned through implementation experience to develop an updated and more fully developed situation analysis, leading over time to improved and more effective programmes. The mechanisms used in this approach include strengthening communication and analytical skills, leading to expanded capacities for decision-making and action.

39. UNICEF will promote, support and strengthen national, subnational and community-based monitoring processes aimed at assessing progress and problems in scaling up high-impact interventions. This may be done by: (a) monitoring changes in coverage determinants of high-impact interventions over time, looking particularly at the situation of the poor, marginalized or hard to reach; (b) participatory analysis of the obstacles to effective coverage and identification of remedial actions, involving duty bearers (health staff, supervisors and managers) and claim holders (community representatives, women and youth groups); and (c) periodic follow-up exercises to monitor whether decisions have been implemented and the actions have produced the expected results.

40. These monitoring activities can be classified according to three general types: (a) community-based, participatory assessment and analysis using the triple-A concept; (b) population-based monitoring to assess progress and constraints in achieving high and equitable coverage; and (c) facility-based monitoring, including the regular use of maternal and child death audits.

41. UNICEF will also support field-based operational research that is well designed, conducted and documented and has good potential to inform decisions about planned policy changes or the introduction of new or improved interventions. UNICEF will strengthen its involvement in large- scale operational research aimed at designing and testing innovative technical, costing and financial solutions and operational strategies for scaling up health and nutrition programmes for mothers and children in resource-poor settings.

V. Implications for UNICEF

42. Achievement of the three strategic results proposed in the strategy is contingent upon inclusive national leadership and ownership of development options oriented towards achieving the Millennium Development Goals. Across development sectors, health and nutrition are among those with the greatest number and variety of actors. This poses significant challenges for in-country coordination

and harmonization. As a dynamic member of United Nations country teams and through the Common Country Assessment (CCA) and UNDAF processes, UNICEF will seek to support and expand the capacities of Governments and national systems for country-led sectoral coordination, planning, reporting, monitoring and evaluation and procurement.

43. In line with the guiding principles and strategic results, the areas of high programmatic intensity will be:

(a) Accelerated implementation at country level;

(b) Advocacy for maternal, newborn and child health and nutrition at all levels, including for the mobilization of resources;

(c) Monitoring and evaluation of programme implementation, with an emphasis on monitoring coverage and impact through MICS, DHS and other population-based surveys;

(d) As the lead agency for the nutrition sector in emergencies, as designated by the Inter-Agency Standing Committee (IASC), UNICEF will lead coordination efforts nationally, regionally and globally.

44. The MTSP for 2006-2009 sets financial targets for the focus area on young child survival and development of 46 and 52 per cent of total projected programme assistance expenditure respectively for regular and other resources. UNICEF estimates that health and nutrition combined will represent 75 per cent of total programme expenditure for this focus area. Projections for the period 2006-2015 are based on weighted annual growth rates for both regular and other resources as per the current MTSP. Average programme expenditures for health and nutrition combined are estimated at $736 million per year during the period covered by the strategy, ranging from an estimated $660 million in 2006 to $835 million in 2015.

45. Regular policy and technical dialogue with bilateral and multilateral technical and financial institutions on joint health and nutrition action will be expanded further. Within the United Nations system, WHO has a recognized global policy-setting, normative and coordination role in public health and is designated by the IASC to be the lead agency on health action during crises. The roles of the World Food Programme (WFP) and UNICEF are increasingly complementary in emergency settings and the provision of guidance on nutrition. UNICEF continues to support the work of the United Nations Standing Committee of Nutrition. UNICEF collaborates with the World Bank and regional development banks to provide technical support for results-based planning and budgeting in specific country contexts. With FAO, the International Fund for Agricultural Development and WFP as the leading United Nations agencies on food security, UNICEF will support joint initiatives that may include production, processing and improved access to locally appropriate, affordable and safe complementary foods, supplemented by joint action in the provision of nutrition knowledge and skills through community-based organizations, such as women's groups, schools and the media.

46. In the increasingly integrated global community, critical decisions affecting children are strongly influenced by leaders of voluntary agencies, interest groups, private companies, philanthropic foundations and academic and research centres. UNICEF will strengthen its partnerships with constituencies that play critical

leadership and mobilizing roles for maternal, newborn and child health and nutrition issues, such as professional associations (e.g., the International Pediatric Association and the International Federation of Gynecology and Obstetrics), parliamentarians, faith-based organizations and religious leaders, youth alliances and sports organizations.

47. UNICEF is a founding partner and co-sponsor of the Partnership for Maternal Newborn and Child Health, the Global Alliance for Vaccines and Immunization, Roll Back Malaria, the Programme for Research and Training in Tropical Diseases, UNAIDS, the Global Alliance for Improved Nutrition and the Food Fortification Initiative. UNICEF collaborates closely with academic and technical institutions such as the London School of Hygiene and Tropical Medicine, the United States Centers for Disease Control and Prevention and the International Centre for Diarrhoeal Disease Research, Bangladesh on ideas, pilot interventions and testing for efficacy and effectiveness to be scaled up at country level. International NGOs and technical networks such as Medecins Sans Frontières, the Micronutrient Initiative, the International Council for the Control of Iodine Deficiency Disorders (IDD), the IDD Network, Helen Keller International, Oxfam, the World Alliance for Breastfeeding Action, the International Baby Food Action Network, CARE and Plan International are involved alongside UNICEF in global advocacy, resource mobilization and country-level action, including emergency response. UNICEF will seek to expand its collaboration with such private foundations as the Bill and Melinda Gates Foundation, Rotary International, Kiwanis, the United Nations Foundation and the Ellison Institute for World Health.

48. To ensure that its policies and recommendations reflect state-of-the-art technical knowledge, particularly with regard to global advocacy and large-scale implementation, UNICEF will periodically convene an independent technical advisory group composed of globally recognized experts.

49. **Situation-specific programming**. The primacy of the country programming approach means that the implementation strategies are not intended to serve as a blueprint for UNICEF-supported programmes and projects in the health and nutrition sectors. This strategy is intended to guide UNICEF programming at the country level, drawing from the most recent scientific evidence and lessons learned. UNICEF fully recognizes the need for the principles presented in this strategy to be adjusted to reflect country-specific needs and policies.

50. A strong comparative advantage of UNICEF at the country level is its capacity to interact with Governments and civil societies at the interface between policy and implementation levels, and to help strengthen the necessary dialogue and interaction between these two levels. UNICEF will continue to play this role, for example by providing operational and technical support to build capacities for scaling up interventions while assisting Governments and civil societies to establish enabling legislative and policy environments as well as national frameworks that support the Millennium Development Goals (e.g., sector-wide approaches (SWAps), poverty reduction strategies (PRSs) and medium-term expenditure frameworks (MTEFs)).

51. **Applying strategic focus**. In fragile States characterized by governance deficits, both in terms of capacities and/or willingness to act, the relative importance of the role of UNICEF in providing more direct operational and technical support for scaling up high-impact health and nutrition interventions necessarily will be

greater than in non-fragile States, where UNICEF assistance will focus predominantly on leveraging policies and knowledge generation.

52. Recognizing that health and nutrition outcomes are not the results of action in the health and nutrition sectors alone, UNICEF will build on its intersectoral experience to promote innovative approaches to address immediate and underlying determinants of maternal, newborn and child health and nutrition.

53. **Core competencies and organizational accountability and support**. At all levels (country, regional and headquarters), UNICEF will need to upgrade standards and methods of operation for its national and international health and nutrition professionals, given the skills and competencies required to design, support implementation of and monitor increasingly complex programmes of cooperation in over 130 countries. Efforts will include the strengthening of mechanisms to provide state-of-the-art technical information and support to staff, and strengthened technical partnerships with collaborating agencies. UNICEF health and nutrition staff provide a solid base for expanding technical capacity within the context of United Nations reform at country level and the UNICEF role in and contribution to global health and nutrition partnerships and alliances.

54. The successful implementation of the joint strategy will require complementary but distinctly different competencies across the organization. At the country level, it will require optimal teamwork, with UNICEF Representatives leading and securing availability and involvement of all relevant staff. UNICEF health and nutrition programme staff in country offices will need to expand their advocacy, technical, managerial and networking skills. Substantially increased emphasis will be placed on in situ continuing education and information exchange, using new communications technologies. At the regional level, emphasis will be placed on providing quality assurance and technical support to country offices, strengthening technical networks among UNICEF country-based officers, collaborating agencies and regional institutions, and on strengthened sectoral monitoring, evaluation and peer review processes. At headquarters, emphasis will be placed on synthesizing evidence, lessons learned and information on maternal, newborn and child health and nutrition issues (status, interventions, strategies and policies) for evidence-based advocacy, policy development, knowledge dissemination and technical guidance. Headquarters staff will also contribute to the shaping of global health and nutrition strategies and partnerships.

55. UNICEF will support the development of capacities in the health and nutrition sectors through a mix of context-specific approaches such as: (a) the development and adaptation of training materials based on international benchmarks; (b) in-service training; (c) formative supervision using problem-solving techniques; (d) mentoring/coaching/tutoring programmes; (e) exchange programmes between high- and low-performing districts and regions; and (f) performance-based incentives. UNICEF support to pre-service training will be limited to the training of peripheral and community health workers through joint programming arrangements with other donor and cooperation agencies. UNICEF will support policies that reduce inequitable urban bias and promote, through context-specific and sustainable incentives, the deployment of health and nutrition personnel in areas with the greatest needs. Finally, UNICEF will strive to abide by and promote good donor practices and greater coordination among partners to avoid drawing from often

limited national capacities to fill their own staffing needs, while promoting recognition of excellence.

56. Reaching the health and nutrition Goals will depend largely on the extent to which households and service providers have timely access to affordable and safe essential health and nutrition commodities, and sufficient knowledge to use them appropriately and effectively. Building on its long history of supply support, both within country programmes and increasingly as procurement services support, UNICEF will offer a mix of programme and procurement services to Governments as a unified basket of support. To do so, UNICEF, with its partners, will help strengthen national capacities to assess and monitor commodity needs based on disease burden studies; accurate forecasting and planning; budgeting and procurement of supplies; in-country logistics and supply-chain management; and the end-use availability of commodities. UNICEF will work with partners to provide leadership in the provision of essential commodities, including pharmaceuticals, vaccines, micronutrients, insecticide-treated materials for the prevention of malaria, and cold-chain equipment and immunization supplies.

57. Promising new developments, such as pneumoccocal and rotavirus vaccines, artemisinin-based combination therapy for the treatment of malaria, or the use of multi-micronutrient supplements and home fortificants, are being considered for introduction in national policies by a number of developing countries. In many cases, access to these new, more efficient products is limited by their global availability and price, or the lack of paediatric formulations (e.g., fixed-dose combinations for paediatric AIDS treatment). Given the potential of these new and under-used products to dramatically reduce child deaths and undernutrition, concerted international action is necessary to make these products available and affordable in resource-poor environments. Through partnerships with global funds, multilateral and bilateral agencies and development banks, and through advocacy with global and regional trade blocs as well as enhanced relations with the industry, UNICEF will develop new supply solutions, propose new financing mechanisms and continue to advocate for partnerships with the private sector to focus on goods most needed by poor families.

VI. Monitoring and evaluating the implementation of the joint strategy

A. Selection of indicators

58. Table 2 shows the indicators chosen to assess the extent to which this strategy is successfully implemented and achieves the strategic results. Additional process, outcome and impact indicators will be elaborated at regional and national levels in the results matrices and integrated monitoring and evaluation frameworks of successive MTSPs. UNICEF will hold itself accountable for achieving the strategic results, and regular monitoring will be used to document progress and identify problems as a basis for continuous improvement of the joint strategy and its implementation.

Table 2
Core indicators for monitoring and evaluating the implementation of the joint strategy

	Indicators *% of countries with:*	*Countries concerned*	*Information sources*
Strategic result 1 Situation analysis:	Relevant, updated and reliable information on priority maternal and child health and nutrition problems and key causes available, used for advocacy and disseminated	All countries	National health and nutrition statistics; Annual (sub)national health and nutrition plans
Implementation approach A Leveraging institutional frameworks through enhanced knowledge and evidence	National policies, plans and budgets based on explicit evidence	All UNICEF programme countries	National frameworks (health and nutrition policies, plans, SWAps, PRSs and MTEFs)
Strategic result 2 Institutional frameworks	National policies, legislation, plans and budgets that supports the MDGs	All UNICEF programme countries	National frameworks (health and nutrition policies, plans, SWAps, PRSs and MTEFs), applications to the Global Fund and Multi-Country AIDS Programme
Implementation approach B Translating policies, legislation, plans and budgets into large-scale accelerated action	At least 90% coverage of immunization, antenatal care, vitamin A supplements and insecticide-treated nets use in all districts; significant improvements in breastfeeding and complementary feeding, oral rehydration therapy and hygiene; affordable quality clinical maternal and child health primary and referral care services available in each poor district.	High U5MR countries and regions	National statistics, United Nations statistics, Health Metrics, MICS, DHS, other health/nutrition surveys, household surveys, Monitoring and Evaluation Reference Group (MERG)
Strategic result 3 Effective coverage	2/3 U5MR reduction and 3/4 maternal mortality rate reduction compared to 1990 and halving of neonatal mortality rate	High U5MR countries and regions	MICS, DHS, other health/nutrition, household surveys, MERG
Implementation approach C Learning by doing and doing better by learning	Coverage with the above interventions monitored at least yearly at all levels and used to improve service delivery	High U5MR countries and regions	National health/nutrition statistics Annual (sub)national health and nutrition plans; national HIV plans

B. Partnerships in monitoring and evaluation

59. Effective monitoring and evaluation are time- and resource-intensive. In addition, the strategic results proposed here are broad, and will require inputs from many agencies, Governments and partners. For these reasons, the UNICEF approach to evaluating the implementation of the joint strategy will be broadly collaborative. For example, partnerships have already been established for joint monitoring and evaluation within the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and Institutional Donors, the Child Health Epidemiology Reference Group for child health and nutrition, and with WFP in the areas of food

and nutrition. In addition, UNICEF will continue to support impact assessment using global instruments such as DHS, MICS and SMART, and support frequent mini-surveys to monitor progress, especially coverage rates. Most countries now have multiple data points on disaggregated mortality trends. Combining that information with the efficacies of key interventions as published in The Lancet increasingly facilitates the monitoring of progress in mortality reduction. Through collaboration and given ongoing improvements in the evidence base, the joint strategy will benefit from the availability of more and better data for use in monitoring trends, mobilizing political will and making strategic adjustments.

VII. Draft decision

60. It is recommended that the Executive Board adopt the following draft decision:

The Executive Board

Endorses the UNICEF joint health and nutrition strategy for 2006-2015 (E/ICEF/2006/8) as the UNICEF official strategy document for programmes of support in the area of health and nutrition.

Annex 1

Priority interventions for Millennium Development Goal 4 and their potential impact on neonatal and under-five mortality, grouped in illustrative service delivery modes

Service Delivery Modes		Pre-conceptual, Antenatal and Delivery Care	Neonatal and postnatal Care	Potential NNMR impact *	Child (post neonatal) Care	Potential U5MR impact
Preventive	Schedulable outreach services	Antenatal Care: -Tetanus immunization -Intermittent presumptive malaria treatment -Screening & management of: ▫ HIV ▫ Syphilis ▫ Micronutrients ▫ Iodine ▫ Iron ▫ Calcium	Vitamin A supplements Post-partum	8% (6-9%)	Childhood Immunization, especially measles and HIB Vitamin A supplements Zinc supplements	12%
Promotional	Family/ Community Care	Clean Delivery	Clean cord care Thermal care Early breastfeeding Extra care of low birth weight infants	24% (15-32%)	Insecticide Treated Bednets Exclusive/continued breast feeding Complementary Feeding Hygiene and Water/Sanitation	35%
Curative	Clinical Care Primary Referral		Early diagnosis & management of pneumonia in newborns		Oral rehydration/zinc Case management of: -Malaria -Diarrhoea -Pneumonia -HIV/AIDS	28%
			Subtotal impact	**28% (18-37%)**	**Subtotal impact**	**50%**
		Skilled maternal and immediate Neonatal care		37% (23-50%)		14%
		Emergency Obstetrical Care	Emergency Neonatal Care			
			Total Impact	**48% (31-61%)**	**Total Impact**	**60%**

* neonatal mortality rate

Annex 2

Analytical framework for maternal and child health and nutrition